Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CENTRE FOR NEURO SKILLS
2658 MOUNT VERNON AVENUE
BAKERSFIELD CA 93306

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
INSURANCE CO OF THE STATE OF PA

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-10-4821-01

MFDR Date Received
JULY 20, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "The insurance carrier, Insurance Company of the State of Pennsylvania (AIG), the TPA – Sedgwick Claims Management Services, and the predecessor, Travelers Insurance Company, agreed to the provider/requestor's rates and approved the essential and necessary services for the patient [injured worker]. These fair and reasonable charges were agreed upon by the carrier, employer, and the provider (Centre for Neuro Skills®). These essential and necessary services have been provided for the patient [injured worker] since he entered the Centre for Neuro Skills® residential program on December 6, 1994. In 2008, and for the last fifteen (15) years, the patient has continued to receive these essential and necessary services and, as they are charged at the fair and reasonable rate agreed upon between the parties, these rates should be paid under rule 134.401(a)(2)."

Amount in Dispute: $15,097.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The two individual Table of Disputed Services indicates that this dispute involves the dates of service 7/1/09 to 7/15/09 and 7/16/09 to 7/31/09, respectively. The DWC-60 shows that this dispute was received by TDI-DWC Medical Fee Dispute Resolution on July 20, 2010. Respondent requests a dismissal of all dates of service included on the first Table of Disputed Services (dates of service 7/1/09 to 7/15/09) because they were not timely filed in accordance with DWC Rule 133.307(c)(1)(A). Respondent also requests a dismissal of the dates of service 7/16/09 to 7/19/09 included within the second Table of Disputed Services. All dates of service in dispute between July 1, 2009 and July 19, 2009 would not have been timely filed… Requestor did not provide proper supporting documentation, and the Respondent relied upon its own methodology to determine a fair and reasonable rate of reimbursement… Further, please see attached internal communication from Requestor admitting that there was no negotiated contract with Respondent regarding the fees for treatment of the Claimant. Accordingly, this document directly contradicts the Requestor's assertion that there was a contract between the parties… Because the services were not preauthorized, the Respondent is not liable for reimbursement of medical costs…."

Response Submitted by: Downs Stanford, PC, 2001 Bryan Street, Suite 4000, Dallas, TX 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 1, 2009 – July 19, 2009	Assisted Living Services – CPT Code 97799	$9,740.00	$0.00
July 20, 2009 – July 31, 2009	Assisted Living Services – CPT Code 97799	$5,357.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on July 20, 2010.
5. The services in dispute were reduced/denied by the respondent with the following reason codes.
    - 4Y8 – Workers Compensation State Fee Schedule adjustment.

Issues

1. Did the respondent raise new denial reasons or defenses after the requestor submitted their request for medical dispute resolution?
2. Did the requestor meet the requirements of 28 Texas Administrative Code §133.307?
3. Did the requestor meet the requirements of 28 Texas Administrative Code §134.1 providing for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline?
4. Is the requestor entitled to reimbursement?

Findings

1. In accordance with 28 Texas Administrative Code §133.307(d)(2)(B) the response shall address only those denial reasons presented to the requestor prior to the date the request for MDR was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. The Respondent, in their position summary, raised the issue of preauthorization not obtained by the requestor. The EOB submitted with the request for dispute resolution did not contain a denial of preauthorization. Therefore, the new denial reason/defense will not be reviewed.
2. The Request for Medical Fee Dispute Resolution was received by the Division on July 20, 2009. In accordance with 28 Texas Administrative Code §133.307(c)(1)(A) dates of service July 1, 2009 through July 19, 2009 were not submitted to the Division in a timely manner and will not be reviewed.
3. The respondent has submitted an EOB with a processing date of August 21, 2009 showing payment was made in the amount of $200.00 per day for all days of service, including those dates of service filed untimely for a total of $6,200.00. The respondent also submitted a Transaction Totals page to support proof of payment per the EOB.
4. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective March 1, 2008, 33 *Texas Register* 626, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(f) which states that "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."
5. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not

provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

6. 28 Texas Administrative Code §133.307(c)(2)(G), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:

   - The requestor's position statement asserts that "These fair and reasonable charges were agreed upon by the carrier, employer, and the provider (Centre for Neuro Skills®)."
   - According to the UB-04 submitted by the Requestor, the amount billed per day for the assisted living care is $487.00. The requestor does not discuss or explain how $487.00 per day is a fair and reasonable reimbursement for the services in this dispute.
   - In support of the requested reimbursement, the requestor submitted an explanation of benefits, from the insurance carrier for the injured employee showing payment in the full amount was made in July of 2009. However, the requestor did not discuss or explain how the sample EOB supports the requestor's position that additional payment is due. The carriers' reimbursement methodologies are not described on the EOB. Nor did the requestor explain or discuss the carriers' methodologies or how the payment amount was determined for the sample EOB.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 27, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.